VIRGINIA PERINATAL HEPATITIS B PREVENTION PROGRAM
Questionnaire on HBsAg Positive Pregnant Patient
(Please report only pregnant women and include copy of patient's lab report)

1. Patient's Name: _____
2. Patient's Address: _____
3. City or County of Residence: _____
4. Home Phone: _____ Work Phone: _____
5. Date of Birth: _____
6. Estimated Date of Delivery:_____
7. Delivery Hospital: _____
8. Has patient been notified concerning her positive test result? ( ) Yes; ( ) No
9. Additional Information (Language Spoken, etc): _____

   _____

Provider Information:

Name: _____

Address: _____

Phone Number: _____

Signature: _____

Please return or fax form to:
Division of Immunization
Virginia Department of Health
Attn: Marie Krauss
109 Governor Street, Room 314 West
Richmond, Virginia 23219
Phone: (804) 864-8055 or 1-800-568-1929
FAX: (804) 864-8089